

missioning. Qualitative research is about posing the right questions to the right people. Perhaps Ham should have been more probing and questioned why these important issues, which have been extensively examined in other commissioning authorities, were not so addressed in the six that he chose to interview.

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## Guidelines on managing hyperlipidaemia

EDITOR,—S Bulusu writes that "practical guidelines on the management of patients with hyperlipidaemia are urgently needed; these should preferably be prepared by a national expert body along the lines of the national cholesterol education programme in the United States."<sup>1</sup> I wish to point out that the Royal College of General Practitioners published such guidelines last year.<sup>2</sup>

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## Managing patients in a persistent vegetative state

EDITOR,—My original articles on managing patients in a persistent vegetative state aimed to generate a mature debate.<sup>1,2</sup> I am not, however, surprised by the emotion they generated in the profession.<sup>3,5</sup> The legal outcome in the case of Tony Bland was always going to be a "no win situation." Many relatives worried that the legal decision would result in patients' treatment being withdrawn and feared the pressure that might be put on them to allow feeding tubes to be removed. Throughout the Bland case patients' relatives and staff in my unit for patients in a persistent vegetative state required enormous support. On the other hand, if the case had gone the other way there would have been other relatives who thought that they had been left in an equally untenable situation.

J G Howe states that Tony Bland received rehabilitation programmes similar to those carried out at Putney. This is not quite the case (and I have studied his management in detail), nor could it be. The treatment that Tony Bland received was excellent for treatment in a general unit with little or no experience of the persistent vegetative state but cannot be compared with treatment by a specialist team that works exclusively with people in such a state. This is not a criticism of Howe's treatment but does make me question what the

courts in a future case will accept as rehabilitation before they decide that feeding can be withdrawn.

It seems to have been left to Howe and M F Helliwell to defend the motives of Mr and Mrs Bland. As an external assessor of Tony Bland, I would like to acknowledge publicly the dedication and love that Tony's family bestowed on him. It is my view that they tolerated the public trauma that they went through because they believed that withdrawing feeding was the greatest demonstration of their love that they could show. We must avoid such courage having to be shown by other families.

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## Retinoblastoma and fetal irradiation

EDITOR,—C A Stiller's editorial on retinoblastoma and low level radiation noted that findings from the Oxford survey of childhood cancers concerning prenatal exposure to x rays have not been published separately for retinoblastoma.<sup>1</sup> Information, though limited, is provided here.

In a series of 15 229 children who had died of cancer before the age of 16 (1953-81) who were individually matched with live controls (that is, 15 229 case-control pairs with interview data) there were 86 retinoblastomas. In this subgroup 27 case-control pairs had records of prenatal exposure to x rays. After the exclusion of three pairs that were concordant for early exposures, there were 14 pairs in which only the case had had fetal irradiation and 10 in which only the control had. Three of the 17 cases that had had fetal irradiation had bilateral tumours.

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- 1 Stiller CA. Retinoblastoma and low level irradiation. *BMJ* 1993;307:461-2. (21 August.)

## Fatigue varies according to where it is measured

EDITOR,—Stephen M Lawrie and Anthony J Pelosi point out that the characteristics of the populations and the severity of symptoms of fatigue vary depending on where fatigue is assessed.<sup>1</sup> In the community more women report "always feeling tired," and women who have children under 6 are twice as likely as men to report this symptom.<sup>2</sup> Women consult general practitioners more commonly than men. David *et al* studied patients attending a general practice for any reason between November 1989 and January 1990 and found that the ratio of men to women attending was one to three.<sup>3</sup> The average fatigue scores of the men and women attending were not significantly different.

We analysed the average fatigue scores of men and women who consulted their general practitioner with fatigue as a main symptom and found that they were not significantly different. For each patient recruited, a patient on the same practice list who was matched for age and sex was sent a fatigue questionnaire. In this comparison group of people

in the community the average fatigue scores of the women were significantly higher than those of the men. Patients who consulted for fatigue were three times more likely to be women than men.<sup>4</sup> This sex ratio is similar to that found by Morrell *et al* in a prospective study of all symptoms presented to doctors in a practice in London over one year.<sup>5</sup>

We agree that there are similarities and differences in the characteristics of population samples when symptoms are measured at different sites—the community, the waiting room of a general practice, and the consulting room—and they require further research.<sup>1,3,4</sup> This would be particularly useful for general practitioners who have hitherto tried to understand why patients consult or ask to be referred and who advise them on the likely diagnosis, management, and prognosis on the basis of intuition, experience, and scientific evidence derived from the fewer than 2% who were referred to specialist care.<sup>5</sup>

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- 1 Lawrie S, Pelosi A. Fatigue in general practice. *BMJ* 1993;307:564. (28 August.)
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- 3 David A, Pelosi A, McDonald E, Stephens D, Ledger D, Rathbone R, *et al*. Tired, weak, or in need of rest: fatigue among general practice attenders. *BMJ* 1990;301:1199-202.
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- 5 Morrell DC. Symptom interpretation in general practice. *J R Coll Gen Pract* 1972;22:297-309.

## Incidence of breast cancer

EDITOR,—Minerva reports that the incidence of breast cancer in women in the United States rose by 33% between 1973 and 1988; in women over 50 it rose by 40%.<sup>1,2</sup> Mortality, however, remained stable over this period. Minerva speculates that these changes are attributable to earlier diagnosis as a result of mammography and that the incidence will level off and the death rate will fall. A more credible explanation for these findings is that the incidence of and mortality from this disease have remained stable and that mortality is not influenced by mammography. The increase in the incidence may well be an artefact of mammography.

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- 1 Minerva. *BMJ* 1993;307:574. (28 August.)
- 2 Swanson GM, Ragheb NE, Lin C-S, Hankey BF, Miller B, Horn-Ross P, *et al*. Breast cancer among black and white women in the 1980s. *Cancer* 1993;72:788-98.

## Sickness certification by general practitioners

EDITOR,—The issue of the *BMJ* published on 11 September contains two apparently conflicting statements. Stuart Handysides reports that "general practitioners say they are not trained to assess people's fitness for work."<sup>1</sup> Secondly, resolution 58 passed by the BMA's annual representative meeting, however, states that "this meeting rejects the government's assertions that general practitioners do not understand the criteria for sickness certification in relation to fitness for work."<sup>2</sup> Should we infer that doctors understand the rules but aren't trained for the job? This situation has arisen because sickness certification

by general practitioners has not been broken down into two separate questions: are general practitioners able to certify fitness for work? should the patient's own general practitioner certify fitness for work?

Prolonged certification is the chief problem and gives rise to most perceived pressure on general practitioners to continue certification. No one wishes to provoke confrontation (and the potential loss of the patient to the practice) when fitness for work is so subjective. There are so many illnesses and so many jobs—and so much unemployment. General practitioners have become almoners, even if they do not determine the size of the alms. At present the rules encourage collusion between a claimant and his or her general practitioner to avoid being assessed as fit for work. This is good neither for the doctor, who feels obliged to err on the side of diagnosing incapacity, nor for the patient, who may become truly disabled and demoralised by the "sick role." It is possible to avoid the conflict between being a doctor and being an almoner only by separating the functions.

Incapacity for work lasting longer than six months, which triggers invalidity benefit, should not be decided by the claimant's general practitioner. There are organisational difficulties in changing current procedures, but the potential savings would be large enough to fund a system possibly based on the regional medical service. This answers our two questions earlier: general practitioners are able to certify in most cases, but after six months the decision should be made by an independent examiner. General practitioners could thus avoid tangling themselves in knots, professing themselves to be incapable of certifying fitness to work when in fact they are trying to avoid conflicts of interest.

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1 Handsides S. GPs are unhappy to police invalidity. *BMJ* 1993;307:644. (11 September.)

2 Resolutions passed by the annual representative meeting 1993. *BMJ* 1993;307: facing p 669 (clinical research edition), facing p 666 (general practice edition), facing p 681 (other editions).

## Writing a departmental handbook

EDITOR,—Having developed a handbook for my hospital's paediatric department over the past six years, I believe that some additional points to those mentioned by Janet McDonagh and colleagues<sup>1</sup> are important in ensuring the longer term success of such a handbook. Our handbook covers three wards with different functions as well as the outpatient department and several maternity wards. Each clinical area has its own folder of guidelines incorporating those elements relevant to it. The full handbook is produced in house in an A5 format and costs about £1 a copy. Forty two copies of the full handbook are required each year. It is reprinted annually, whereas the ward guidelines are updated as often as required.

Guidelines developed from departmental audit sessions are incorporated into the handbook and printed in bold when there is agreement that they represent departmental guidelines. The role of the consultants in the department is crucial. One consultant, with the help of middle grade staff, should be responsible for ensuring that the handbook is kept up to date, but the commitment of all the consultants in the department is important.

McDonagh and colleagues mention that one benefit of compiling the handbook on a word processor is that this facilitates amendments. There are other important benefits. Our departmental handbook now runs to 178 pages. The word

processor allows us to produce an index, which is five pages long, and a table of contents: without these it would be difficult to use the handbook. It is crucial to keep a record of when each amendment to the handbook is made, otherwise it may prove impossible to know what the guidelines were several years previously. This may be important for medicolegal reasons. A word processor allows unprinted comments and the dates of changes to be inserted into the document, and a separate file is kept of all previous guidelines.

I believe that departmental handbooks have an important role in education and audit. The main investment is in consultant and middle grade doctors' time.

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1 McDonagh J, Clarke F, Veale D. How to write a departmental handbook for junior staff. *BMJ* 1993;307:553-5. (28 August.)

## Complaints to the GMC

EDITOR,—T G Barrett comments on statistics published in the General Medical Council's annual report relating to its disciplinary work.<sup>1</sup> Barrett suggests that the council is less concerned with potential harm to patients than with doctors' personal conduct, citing as evidence the fact that, in 1992, 86 complaints about the personal conduct of doctors were referred to the preliminary proceedings committee, compared with 38 complaints relating to the standard of the medical treatment provided by doctors.

Barrett's letter illustrates the dangers of looking at one or two figures from a statistical report in isolation. Among all the types of complaints referred to the preliminary proceedings committee the largest category, in all recent years, has been complaints about the standards of medical care. Last year these amounted to 38 cases out of 124. The 86 cases mentioned by Barrett are the combined total of all the other categories of misconduct, including, for example, misuse of alcohol or drugs by doctors, violence or indecency towards patients, false claims to qualifications, falsification of research data, and dishonesty. A high proportion of those 86 cases therefore related to conduct that was potentially damaging to the health and welfare of patients and the general public.

In addition, the annual report points out that the General Medical Council has other procedures for acting on complaints besides referring them to its preliminary proceedings committee. Many cases are considered and resolved by sending letters of advice about their future conduct to the doctors concerned. Forty five cases relating to medical treatment were dealt with in that way during 1992.

These figures therefore show that the council is indeed concerned with protecting patients through its disciplinary procedures.

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1 Barrett TG. General Medical Council. *BMJ* 1993;307:628. (4 September.)

## Preparing for retirement

### Go on a course

EDITOR,—People in England who would like advice about their retirement, which Harold Jacobs thinks he has lacked, have far more opportunity than he seems to have in Canada.<sup>1</sup> Courses are run by the NHS (as an employer), the Pre-Retirement Association, the Workers' Educational Association, and other bodies: ar-

rangements vary from area to area. One thing that I have found fascinating when taking part in many of these courses over many years is the similarity between the questions raised by doctors, other hospital staff (professional or unskilled), and people of all sorts outside hospital work. Thus special courses for doctors are probably not necessary.

Jacobs also suggests, reasonably, that the subject should be approached earlier: five to 10 years earlier has been shown to be a good time. The trouble is that if "management" tells you when you are in your 50s, "It's time you prepared for retirement," you fear the worst.

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1 Jacobs H. Facing the future backwards. *BMJ* 1993;307:689. (11 September.)

## It's easier for women

EDITOR,—I agree with Harold Jacobs that men can find retirement from a busy, useful professional life a shock.<sup>1</sup> Women may find retirement easier for several reasons. Many continue to run a house, which requires an established routine to be maintained. Many will have experienced a change in their work pattern earlier in their lives when moving from full time work to part time work or not working while their families were young; thus they will already have coped once with loss of professional status.

Perhaps men would adapt better if, instead of changing abruptly from full time work to not working, they were allowed a phase of part time work. This would make part time schemes more fairly distributed—early in women's careers, late in men's careers.

Helping people adapt to retirement might also save them from the indignity of hanging on beyond their span of competence.

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1 Jacobs H. Facing the future backwards. *BMJ* 1993;307:689. (11 September.)

## Junior surgeons lack practical experience

EDITOR,—Minimal access surgery has resulted in an increasing number of procedures that were previously performed by juniors being performed by senior surgeons. Surgical skills are gained by "hands on" experience, and the reduction in opportunities to acquire these skills is causing concern among surgical trainees. To assess the effects of minimal access surgery on surgical training we questioned 89 trainee surgeons about their experience of cholecystectomy, the most commonly performed laparoscopic procedure. Before laparoscopic cholecystectomy was introduced the mean number of open procedures performed by the trainees in their first year was 19. The number is now 0.5.

This highlights the difficulties experienced by juniors in training. Not only are more procedures being performed laparoscopically but a considerable proportion of open procedures are also being performed by consultants. This is because some are converted laparoscopic procedures while other cases are not considered to be suitable for laparoscopic surgery because they are likely to prove technically difficult. Other procedures such as appendicectomies and hernia repair are similarly affected, although to a lesser degree.

Though we accept that when any new technique is introduced the number of procedures performed by juniors will fall, a cohort of trainees is gaining